DEPARTMENT OF STATE HEALTH SERVICES

Radiation Safety Licensing Branch
Mammography Certification
Amendment Application for Facility Performing Stereotactic Biopsy, Needle Localizations, or Image Guided Radiotherapy

Complete this application and submit to either address below. (Use supplemental sheets as necessary) Retain a copy of the application for your files.

U.S. Postal service address:
Department of State Health Services
Radiation Safety Licensing Branch
Mammography Certification Program
P.O. Box 149347, Mail Code (MC) 2835
Austin, Texas 78714-9347

Overnight/express service address
Department of State Health Services
Radiation Safety Licensing Branch
Mammography Certification Program
1100 West 49th Street
Austin, Texas 78756

Mammography Certification Program (512) 834-6688 - Fax (512) 834-6716

Section 1: General Information

Mammography Certification Number:_____

Legal Name of Facility:_____
(Name should match that on Business Information Form RC 226-1)

Doing Business As (if applicable):_____
(Name should match that on Business Information Form RC 226-1)

County_____

Mailing Address: (Street/City/State/Zip) Machine Use Location Address: (Street/City/State/Zip)
(If multiple use locations, use additional sheets)

_____ _____

_____ _____

_____ _____

Facility Phone Number: _____ Fax No.:_____

Radiation Safety Officer (RSO): _____
Attach qualifications as required in 25 TAC § 289.226(t)(1).

Telephone No.:_____ E-mail address:_____

Contact Person & Title:_____

Telephone No.:_____E-mail address:_____

Total number of machines:
Stereotactic Biopsy Units:_____ Needle Localization Only Units:____

Image Guided Radiotherapy Units _____. Stereotactic Biopsy Attachments:_____

Section 2: Equipment Information

Complete this section for each mammographic biopsy or needle localization unit.
Include a copy of the medical physicist's survey report for each machine and corrective actions for all failures and/or deficiencies noted. (The survey report must be dated within the past 6 months).

Indicate the service for which this unit is used: ☐Needle Localization ☐Breast Biopsy

1. Control Panel Manufacturer: _____ Control Panel Model Name & Number: _____ Control Panel Serial Number _____

   Stereotactic Biopsy Attachment Manufacturer _____ Model Number _____ Serial Number _____

2. Type of Imaging System: ☐Screen/Film ☐Digital

3. Location: ☐ Onsite ☐ Mobile

Section 3: Accreditation Information

Accreditation is voluntary and only available through the American College of Radiology

Please check if unit is accredited ☐ American College of Radiology (ACR)

Section 4: Mobile Service Operation

Authorization from the Department is required prior to initiating mobile service operations.

For mobile mammography service operations complete this section.
[25 TAC§289.230(l)(8)]

Main location where machine and records. will be maintained for inspection. This must be a street address.

_____

Street City State Zip

Attach a sketch or description of the normal configuration of the mammography unit's use including the operator's position and any ancillary personnel's location during exposures. If a mobile van is used with a fixed unit inside, furnish the floor plan indicating protective shielding and the operator's location.

Submit a current copy of the mobile service operations operating and safety procedures regarding radiological practices for protection of patients, operators, employees, and the general public.

Section 5: Signatures

I certify that all information submitted with this application is true and current to the best of my knowledge.

Typed or printed name of person completing the application	Date	Signature

Typed or printed name and title	Date	Signature

This shall be the signature of the Administrator, President, Chief Executive Officer, Owner or Partner of the facility.

As a licensed physician, I affirm that I am associated with this applicant and provide supervision to non-practitioners administering radiation to human beings.

Typed or printed name of licensed physician	Date	Signature

(Include current copy of Texas Board of Medical Examiner's License)

I assume the responsibilities of **RSO** as described in 25 TAC §289.226(t)(2) for the facilities listed in this application. I certify that all information submitted with this application is true and current to the best of my knowledge.

Typed or printed name of RSO	Date	Signature

NOTE: Please include completed Business Information Form BRC 226-1

PRIVACY NOTIFICATION: If you are applying as an individual, with few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)